STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155064	B. WIN		<del></del>	03/07/20	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L			SOUTH LAFOUNTAIN STREET		
FAIRMOI	NT REHABILITATIO	N CENTER, LLC		1	MO, IN46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	This visit was for	r the investigation of	F000	00	The staements made on the P	lan	
	complaint IN000	086620.			of Correction are not an		
	1				admission to, and do not		
	Complaint IN000	086620 - Substantiated,			constitute an agreement with, talleged deficiencies herein. The		
		ciencies related to the			Plan of Correction is offered		
		ed at F-157, F-246,			because it is required by State		
	1 ~				and Federal law.		
	F-272, F-325, an	d F-32/.					
	Unrelated deficie	ency cited					
	Survey date: Mar	rch 4 and 7, 2011					
	Facility number:						
	Provider number						
	AIM number: 10	0274850					
	Survey team:						
	DeAnn Mankell,	RN					
	, ,						
	Census bed type:	:					
	SNF: 14						
	SNF/NF: 48	3					
		52					
	Census payor typ	be:					
	Medicare: 14						
	Medicaid: 44						
	Other: 4						
	Total: 62						
	101.01.02						
	Sample: 3						
	Supplemental Sa	mple: 4					
	These deficiencies also reflect state						
I A DOR AMES			D I 4757 175 =		The state of the s	[	OVO DATE
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIC	JNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3HY411 Facility ID:

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	LETED
		155064	B. WIN			03/07/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET		
FAIRMONT REHABILITATION CENTER, LLC			KOKON	/Ю, IN46902			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	findings in accor Quality review com Cathy Emswiller R1	•					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3HY411

Facility ID: 000025

If continuation sheet

Page 2 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED	
AND PLAN	OF CORRECTION	155064	A. BUII		00	03/07/2011
		100004	B. WIN		ADDRESS OWN STATE THE CORE	00/01/2011
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE SOUTH LAFOUNTAIN STREET	
FAIRMON	NT REHABILITATIO	N CENTER, LLC		l	MO, IN46902	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0157	Based on recor	rd review, and	F015	57	Corrective Action: Resident B	04/06/2011
SS=D	interview, the	facility failed to			MD notified on 3/7/2011 @ 2:0 PM of residents weight loss. N	
	notify the resid	dent's physician of a			order for Megace ES received	
	-	ight loss in a 3 week			and MD requested that all	
	-	2 residents with			refusals be documneted in the clinical record. Residents	
	_				continuously refused Megace E	s
	weight loss in	a sample of 3			. MD notified and order receive	ed
	(Resident B).				to DC on 3/10/2011. Order from	n
					MD to add fortified foods.ldentification: Current	
	Findings include	de:			residents have the potential to	be
					affected by this deficient practic	
	1. Resident B'	s clinical record was			Licensed staff were re- inservice on the Policy on Notification.	ced
	reviewed on 3/	/7/11 at 9:26 A.M.			System Change: Clinical record	ds
	Teviewed on 3/	// 11 dt /.20 /1.1v1.			and 24 hour reports are review	
	D 11 (D) 1				daily (Monday thru Friday) in o	
		iagnoses included,			clinical meetings. Clinical recor are taken to the meeting and	as
		mited to, arthritis,			reviewed to assure	
	osteoporosis, h	nypertension, anxiety,			appropriate documentation of N	
	constipation, a	nd a history of			and family have been complete Failure to comply with policy with	
	dehydration.				result in one- one inservice or	
					Counseling Corrective Action	
	   Resident B's 20	dmission weight was			given.Monitoring: DON/Design	
		· ·			or Charge reviews clinical reco in clinical meetings daily	ras
	117 pounds on	4/0/11.			(Monday thru Friday) Audits a	re
					completed weekly for 3 weeks	
		ext weight was 109.4			monthly for 3 months and	
	pounds on 2/28	8/11. She was			quarterly for 3 quarters. Any identified trends ar reviewed in	
	reweighed late	r in the week and			our monthly clinical meetings a	
	weighed 109.2	pounds. This was a			Improvementt Plans	
	-	oss within 3 weeks			implemented.Addendum: Any identiifed trends will be reviewe	ad
as documented by the facility.			at the monthly Clinical meeting			
			Any identified issues will			
					be referred to Quarterly QAA	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 03/07/2011
	ROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP CODE SOUTH LAFOUNTAIN STREET MO, IN46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	The physician (extra strength (suspension) 6 (milligrams)/d 2/21/11. This days.  This order was with the reason as "appetite still the MAR (Me Administration February 2011 Megace was c 2/26, 2/27, 2/2 blank. This chresident didn't Megace. There (discontinued)  The physician'd 2/28/11 indical (discontinue) in the strength of the physician'd 2/28/11 indical (discontinue) in the p	ordered "Megace ES ) oral susp 25 mg ay (for) anorexia." on order was for 30  s clarified on 2/22/11 in for the medication imulant."  edication in Record) for indicated the ircled on 2/23, 2/24, is. The 2/25 date was inarting indicated the receive any of the e was a DC on 2/28/11.	TAG	committee. The QAA commit may discontinue any further montioring if no trends are identified.	
		note dated 3/3/11 r (March) wt (weight)			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE S COMPL		
AND I LAN	or course now	155064	A. BUI B. WIN	LDING		03/07/2	
NAME OF B			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	PROVIDER OR SUPPLIER			1	OUTH LAFOUNTAIN STREET		
	NT REHABILITATIO			KOKON	//O, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	109.4 # down	7.6 # in 30 days					
	(6%). Wt. loss	due to low food					
	intake. Res hav	ving emesis, intake					
	25%. Receivii	ng shake tid (3 times					
	a day). Will a	dd fortified foods"					
	The clinical re	cord lacked any					
	indication of the	ne physician being					
	notified of the	6% weight loss.					
		rview with the DON					
	on 3/7/11 at 1:						
		vas unaware of the					
	1	ician being notified					
	·	oss, but he would be					
	notified today.						
		*****					
		Weight Management					
		ions" provided by the					
		1 at 1:20 P.M.,					
		The physician, the					
	registered diet						
	1 -	gal representative are					
		mmediately when a					
	resident has de						
		planned weight loss					
	1 -	ond promptly to the					
		rs and the register					
	dietitian's reco	mmendations."					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155064	A. BUI B. WIN	ILDING NG		03/07/2	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREE	Т	
FAIRMO	NT REHABILITATION	ON CENTER, LLC		KOKON	ЛО, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
	This federal to IN00086620.  3.1-5(a)(2) 3.1-5(a)(3)	ag relates to complaint					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3HY411

Facility ID: 000025

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155064 03/07/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3518 SOUTH LAFOUNTAIN STREET FAIRMONT REHABILITATION CENTER, LLC KOKOMO, IN46902 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Correction: Residents A, DE, F, F0246 F0246 04/06/2011 Based on observation the facility and G had their call lights SS=E failed to ensure residents were able correctly placed at time of survey to reach their call lights for 5 tour.Identification: Current residents are at risk with this residents with 1 resident in the deficient practice. Inserviced sample of 3 residents and 4 staff on correct placementt of call lights. When residents are in residents in the supplemental chairs or out of bed the call light sample of 4 residents (Resident A, must be placed in reach to assure accsess of staff for assistance. Resident D, Resident E, Resident F, System Change: A review of the and Resident G). current system was addressed with the facility staff regarding the appropriate placement of call Findings include: lightsfor current residents. Nursing staff was re inserviced on the appropriate procedure. 1. During the facility tour on Staff failing to comply with this 3/4/11 with the DON (Director of requirement will have one -one inservice or a Counseling Nurses) at 10:00 A.M., Resident Corrective Action D's room was observed. Resident completed.Monitoring: Call light audit are being completed D was lying in her bed. Her call weekly for 3 weeks, monthly for light was on the floor. 3 months and quarterly for 3 quarters. Also, audits will be completed on weekends to 2. During the facility tour on 3/4/11assure compliance. Any trends with the DON (Director of Nurses) identified will be reviewed at our monthly clinical meeting with at 10:05 A.M., Resident E's room Improvement Plans implemented. was observed. Resident E was Addendum: Call lights will be completed on all shifts 7 days a lying in her bed. Her call light was week. On an ongoing basis call clipped to the curtain out of her light audits will be completed on 10% of residents able to utilize reach. call lights at-least weekly. Any identified trends will be reviewed at our Clinical meeting held 3. During the facility tour on 3/4/11monthly with referral to our with the DON (Director of Nurses) Quarterly QAA meeting. At the

000025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		155064	B. WING			03/07/2	011	
NAME OF P	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE					
			3518 SOUTH LAFOUNTAIN STREET					
FAIRMO	NT REHABILITATIO	ON CENTER, LLC	KOKOMO, IN46902					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI		TΕ	COMPLETION	
TAG	1	R LSC IDENTIFYING INFORMATION)	-	TAG	conclusion of no further trending	) a	DATE	
		, Resident F's room			issues the monitoring may be	19		
	l	Resident F was			discontinued.			
	lying in his be	ed. His call light was						
	on the floor.							
	4. During the	facility tour on 3/4/11						
	_	(Director of Nurses)						
		, Resident G's room						
		Resident G was						
	1 * *	ed. Her call light was						
	**	curtain out of his						
	reach.							
	5. During the	facility tour on 3/4/11						
	at 10:15 A.M.	, with the DON						
	(Director of N	Jurses), Resident A's						
	`	clipped to the curtain						
	_	out of the reach of						
		ho was lying in bed.						
	l the resident w	no was lying in oca.						
	This follows 14.	a mafama ta accessiaint						
		ag refers to complaint						
	IN00086620.							
	3.1-3(v)(1)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3HY411

Facility ID:

000025

If continuation sheet

Page 8 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/07/2011		
NAME OF PROVIDER OR SI		ER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE  3518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902				
PREFIX (EACH D	FICIENCY MUST I	FOF DEFICIENCIES BE PERCEDED BY FULL FIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
interview correctly dehydrating place to re-asses history or disconting dehydrating sample of Resident.  Findings  1. Resident reviewed.  Resident but were kidney disartery dis	o prevent des 1 resident dehydration ing a care pon for 2 of 3 (Resident 3).  Include:  Int A's clinical on 3/4/11 at the A's diagnost of limited the case, anemical CVA (cerestroke]) with HTN (hyporonary artedder cancer	railed to ident with ident with a chydration and t with a chosen before plan for a residents in a t A and cal record was t 10:38 A.M.  The sincluded, to chronic chia, coronary a, multi-infarct bral vascular ch right arm certension), ery bypass r, and	F023	72	Corrective Action: Resident's Dehydration Risk Assessment was reassessed on 3/4/2011 a appropriate intervention were implemented. Resident's A Dehydration Risk assessment was reassessed on 3/21/2011 and appropriaqte interventions implemented. Identification: Current resident's are potentia at risk for this deficient practice. New baseline Dehydration Risk Assessments have been completed for currer resident's. Licensed staff re-inserviced on new process. System Change new Hydration Risk Evaluation has been implement to better evaluate residents hydration needs. All new admissions Intake and Output be assessed for 72 hours per facility protocol to dertermine resident's fluid intake needs. If determined to be at risk for dehydration resident will be placed on I & O. Monitoring: D. Designee or Charge nurse will review daily intake records for residents on I & O. If fluid neare not met the attending MD be notified for further orders. Audits of I & O records will be cmpleted weekly for 3 weeks, monthly for 3 months and quarterly for 3 qarters. Any identified trends will be review at our monthly clinical meeting with Improvement Plans implemented. Adendum: Any identified trends will be review at our sidents will be review at our monthly clinical meeting with Improvement Plans implemented. Adendum: Any identified trends will be review at our sidentified trends will be review.	and  Illy  Sent  Anted  will  ON  I  eds  will	04/06/2011

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		A. BUII B. WIN	LDING	ONSTRUCTION  00	(X3) DATE S COMPLI 03/07/20	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	facility on 2/1/ A "Dehydration was completed score was 8 in was at high rise."  A progress not dated 2/20/11 had "1. acute redehydration. 2 failure"  Resident A ret on 2/24/2011 we "hypernatreming failure."  The "Dehydrate Assessment" we 2/24/11. The redehydration indicating the risk for dehydration on 3/4/11 at 32 indicated both not correct. The task of the correct.	In Risk Assessment" If on 2/1/11. The total dicating the resident is for dehydration.  The from the hospital indicated the resident renal failure related to 2. Chronic renal  The facility with diagnoses of a, acute renal  The facility with diagnoses of a country and to the facility with diagnoses of a country are renal  The facility with diagnoses of a country are renal  The facility with diagnoses of a country are resident was at high reation.			at the monthly Clinical meeting Any continuing identifed issues will be referred to our Quarterl QAA committee. The QAA committee may discontinue ar further montoring if no trends a identified.	s y ny	DITE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S		
THE TEAM	or connection	155064	A. BUI B. WIN	LDING	<del></del>	03/07/20	
NAME OF F	ADOLADED OF CLASH IED		D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	OUTH LAFOUNTAIN STREET		
	NT REHABILITATIO	·			/IO, IN46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
,	fluids offered	during the day"					
	marked or the	correct number for					
	predisposing c	onditions, nor the					
	increased lab v	values. Having these					
	marked would	have made the total					
	number higher	The risk would not					
	be changed as	the resident was at					
	high risk for d	ehydration.					
		's clinical record was					
	reviewed on 3	/7/11 at 9:26 A.M.					
	D :1 ( D) 1						
		iagnoses included,					
		mited to, arthritis,					
	_	nypertension, anxiety,					
	1 ~	and a history of					
	dehydration.						
	Dogidant D ha	d a "Dobudration					
		d a "Dehydration					
		ent" completed on					
	1 *	Imission. The total					
		placing the resident at					
	high risk for d	cnyuranon.					
	Resident R had	d a care plan for					
		for the problem of					
		risk for dehydration					
	l ` ′	dx. (diagnosis) of					
		This care plan was					
	piicumoma.	ims care plan was					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIH	LDING	00	COMP	LETED
		155064	B. WIN			03/07/2	2011
		1	D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	OUTH LAFOUNTAIN STREE	Т	
FAIRMONT REHABILITATION CENTER, LLC			1	лО, IN46902	-		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	discontinued of	on 2/24/11.					
	During an inte	erview with the MDS					
	(Minimum Da	ata Set) coordinator on					
	`	3 A.M., she indicated					
		ntinued the care plan					
		-					
		esident no longer had					
	the pneumoni	<ul> <li>a. She indicated a</li> </ul>					
	new assessme	ent to determine if the					
	resident was r	no longer at risk for					
	dehydration h						
	1 -	ad not been					
	completed.						
		ag refers for complaint					
	IN00086620.						
	3.1-31(a)						
	3.1-31(c)(1)						
	3.1-31(c)(2)						
	3.1-31(c)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3HY411

Facility ID:

000025

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	JLTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155064	A. BUII		00	03/07/2011
		100004	B. WIN		ADDDESS OWN STATE THE CODE	00/07/2011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE SOUTH LAFOUNTAIN STREET	
FAIRMON	NT REHABILITATIO	N CENTER, LLC			MO, IN46902	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F0281		rvation, record	F028		Correction: Residents A dress	
SS=D	review, and int	terview, the facility			to R wrist was changed immediately when brought to	
	failed to chang	•			RN's attention and dated and	
	-	yound on a wrist for 1			timed as per policy. The	
	_	with a wound on his			dressisng change was noted o the TAR and signed off by nurs	
					completeing dressing	)-C
	wiist in a saint	ole of 3 (Resident A).			change.ldentification: Current	
	TO 11 1 1 1				residents potentially are affected by this deficient pratice. Licens	
	Finding includ	e:			Nursing staff to review TAR's o	
					daily basis per shift for complet	tion
	1. Resident A	was observed in the			of treatments. If treament has not been completed as ordered	l l
	physical therap	oy room on 3/7/11 at			,the MD and family are to be	<b>'</b>
	11:21 A.M. H	e had an undated			notified and treatment complete	ed
	dressing on his	s right wrist. During			with the appropriate documentation on the	
	an interview at	-			TAR.System Change:	
		py Manager looked			Licensed Staff was re- inservice	ced
	-	and indicated there			on appropriate treatment procedure. Any staff not	
	_	on the dressing.			complying will have one - one	
	was not a date	on the dressing.			inservice completed or receive	
	D: 1 4 A ! 4				Counseling Corrective Action.Monitoring: Treatment	
		eatment record was			records are being reviewed da	ily
		7/11 at 11:23 A.M.			by DON / Designee or Charge	
		record indicated an			Nurse to assure treatments ar being completed per MD order	
	order for "Clea	anse (R) (right) hand			and approproiate documentation	
	skin tear c (wit	th) N.S. (normal			is recorded. Audits will be	
	saline), pat dry	, apply bacitracin (an			completed weekly for 3 weeks monthly for 3 months and	,
	antibiotic ointr	nent), cover c			quarterly for 3 quarters. Any	
	non-adhesive p	oad, wrap c kerlix (a			trends identified will be reviewed	ed
	_	ays then re-eval			at our monthly clincal meeting with Improvement	
	(evaluate)." There were initials for			Plans implemented. Addendun	n:	
		on 3/3/11. There			Any identified trends will be	_
	the 10-0 shift (	)11 J/ J/ 11 . THOIC			reviewed at the monthly Clinica	al

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPI	LETED
		155064	B. WIN			03/07/2	2011
NAME OF I	DROWDER OF CURRY IEI		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	ļ.	
NAME OF F	PROVIDER OR SUPPLIEI	K		3518 S	OUTH LAFOUNTAIN STREET		
FAIRMONT REHABILITATION CENTER, LLC				KOKON	MO, IN46902		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION
TAG	<del>\</del>	R LSC IDENTIFYING INFORMATION)	+	TAG	· · · · · · · · · · · · · · · · · · ·	ifod	DATE
		ls for 3/4/11, 3/5/11,			meeting. Any continuing ident issues will be referred to our	iieu	
	and 3/6/11.				Quarterly QAA meeting. The		
					QAA committee may discontin	ue	
	Resident A's p	physician's orders			any further montiotring if no trends are idetified.		
	were reviewed	d on 3/7/11 at 11:25			tienas are idetiliea.		
	A.M. The ord	ders indicated an order					
	for "Cleanse (	(R) (right) hand skin					
	tear c (with) N	N.S. (normal saline),					
	pat dry, apply	bacitracin, cover c					
	non-adhesive	pad, wrap c kerlix x 7					
	days then re-e	eval (evaluate)."					
	During an inte	erview with the DON					
	(Director of N	Jurses) on 3/7/11 at					
	11:40 A.M tl	he DON indicated the					
	· ·	ge should have been					
	charted, if it v	•					
	i charteu, ii it v	vas udile.					
	3.1-35(g)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3HY411

000025

Facility ID:

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155064	B. WIN	G		03/07/2011	
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		$\neg$
					SOUTH LAFOUNTAIN STREET		
FAIRMON	NT REHABILITATIO	N CENTER, LLC		KOKO	MO, IN46902		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	ヿ
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	_
F0325	Based on obse	rvation, record	F032	25	Corrective Action: Resident B meal intake record was reviewed	04/06/2011	
SS=G	review, and int	terview, the facility			and her weight loss assessed.	eu	
	failed to imple	ment approaches to			MD and family notified. The ord	der	
	_	ficant weight loss in			for chocolate shakes was		
	_				reviewed and added to the MA	R	
	_	d for 1 of 2 residents			to assure that appropriate		
	with weight lo	oss in a sample of 3			documentation of residents consumption.Identification: Cur	re	
	(Resident B).				nt residents have the potential		
	,				be affected by this deficient		
	Eindings in als	da.			practice. An inservice on Facili		
	Findings include:  1. Upon interview, during the				Weight Management Program	for	
					DON, CDM and ancillary clerk was completed. Weekly weight		
					meetings are conducted.		
	facility tour on	3/4/11 at 10:05			Supportive documentation and		
		DON (director of			interventions are included in th		
	Ť.	`			weeky report. Copies are provi	de	
	,	ent B was identified			to the Administrator. System Change: CDM/Designee review	v	
	as having weig	ght loss.			Food Consumption records.	<b>v</b>	
					Residents having decreased		
	Resident B wa	s observed on 3/4/11			food intake or refusals of meals	l l	
		45 P.M. She ate 40%			are reviewed at clinical meetin	9	
					daily (Monday thru Friday).  Resdients are offered substitut		
	of her food and	d 80% of the fluids.			. Residents continuing to have	<b>I</b>	
					decreased appetite are referred	I	
	Resident B's cl	linical record was			to the RD for further dietary		
		/7/11 at 9:26 A.M.			interventions. MD and family a	re	
	15 115 11 64 611 57	,, 11 46 7.20 11.111.			notifed by nursing, with	ha	
	<b>.</b>				appropriate documentation in t clinical record.Monitoring:	lie	
		iagnoses included,			CDM/Designee review food		
	but were not li	mited to, arthritis,			intake records and report any		
	osteoporosis. h	nypertension, anxiety,			idetified issues to the DON.		
	_	• •			DON/designee will follow up wi	th	
	constipation, and a history of				notification of family and MD.  Audits are completed weekly for	nr 3	
	dehydration.				weeks, monthly for 3 months a		
					quarterly for 3 quarters. Any		

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		A. BUIL	DING	NSTRUCTION 00	(X3) DATE S COMPLI 03/07/20	ETED	
	PROVIDER OR SUPPLIER		B. WING 05/67/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  3518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Resident B's a 117 pounds on Resident B's n pounds on 2/2 reweighed late weighed 109.2 7.6 % weight I per the facility Resident B's w 112 pounds. Tweighed after The dietary madated 2/16/11 indicated " intakes bkfst (lunch 75%, Di 600-900 cc per recommend actid between mi intakes and dx dehydration There was a pl 2/16/11 for "C Shakes TID (3	dmission weight was 2/8/11.  ext weight was 109.4 8/11. She was a first in the week and a pounds. This was a coss within 3 weeks calculation.  reight on 3/7/11 was the resident was lunch.  anager's progress note at 8:06 A.M., weight is 117 # breakfast) 15-50%, nner 25-50%. Fluids at meals. Will lid Choc Healthshakes eals due to low (diagnosis)			identified trends are reviewed a our monthly clincal meetings a Improvement Plans Implemented. Addendum: Nutrition at Risk Meetings will continue weekly., the DON, CE and ancillary clerk will attend the meetings. Any resident who have experienced a weight loss or gwill be reviewed at this meeting and placed on a weekly weight as deemed necessary. Reside who exhibit a 5% weight loss or gain will be included in the week audits. Any identified trends with the reviewed thru our monthly Clinical meeting and a report given at our Quarterly QAA meeting.	DM ne as ain g tts nts or	

000025

NAME OF PROVIDER OR SUPPLIER  FAIRMONT REHABILITATION CENTER, LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  3518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	3518 SOUTH LAFOUNTAIN STREET					
PROVIDERS PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP	(X5) PLETION PATE					
Review of the MAR (Medication Administration Record) and TAR (Treatment Administration Record) indicated a lack of documentation of the chocolate Health Shakes for February or March 2011.  During an interview with LPN #1 on 3/7/11 at 10:30 A.M., she indicated she didn't chart the health shake intakes anywhere in the clinical record.  When Resident B was interviewed on 3/7/11 at 11:45 A.M., she indicated she didn't get any shakes between meals. The visitor in the room with her indicated she had not seen any shakes for the resident, either.  Resident B's "Nutritional History/Assessment" dated 2/17/11 indicated she had "some depletion of visceral prot (protein) stores, received vitamin supplements present diet intake inadequate to meet needs, wt. (weight) loss likely,						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155064	B. WIN			03/07/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
EVIDWO	NT DEHARII ITATIO	NICENTED IIC		1	OUTH LAFOUNTAIN STREET 100, IN46902	
	ONT REHABILITATION CENTER, LLC			<u>.</u>	10, 1140902	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	will request Megace ES to stimulate					
	appetite."					
	аррене.					
	The physician	ordered "Magaza ES				
	1	ordered "Megace ES				
	(extra strength	· •				
	(suspension) 6	0				
		ay (for) anorexia." on				
	2/21/11. This	order was for 30				
	days.					
	This order was	s clarified on 2/22/11				
	with the reason	n for the medication				
	as "appetite sti	mulant."				
	The MAR (Me	edication				
	Administration					
	February 2011	<i>'</i>				
	1 ,	ircled on 2/23, 2/24,				
	_					
		8. The 2/25 date was				
		narting indicated the				
		receive any of the				
	Megace. There					
	(discontinued)	on 2/28/11.				
	During an inte	rview with the DON				
	on 4/7/11 at 11	:50 A.M., she didn't				
	know why the	resident didn't				
	1	egace as there was no				
		the back of the				
	2.1p.minution of	THE CHAIL OF HIS				

000025

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155064		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  03/07/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	Е	(X5) COMPLETION DATE
TAG	MAR. The number on 2/23/11 and had refused all of the other day with taking measures in otes a measure of the food intakes and lunch, and 2/27/11 intakes and lunch	rses' notes indicated 12/16/11, the resident 12/16/11, the resident 12/16/11, the resident 13 medications, but all 14 ys she was compliant redications or there 15 at 15		TAG		(IATE	DATE
	2/28/11 intake	of 50% at breakfast,					

	OF CORRECTION  OF CORRECTION  155064	(X2) MULTIPLE CON  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 03/07/2011
	PROVIDER OR SUPPLIER  NT REHABILITATION CENTER, LLC	3518 SO	DRESS, CITY, STATE, ZIP CODE UTH LAFOUNTAIN STREE D, IN46902	Т
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	10% at lunch, and bites at dinner			
	The physician's orders dated 2/28/11 indicated "D/C (discontinue) Megace ES susp 625 mg/day D/T (due to) increased appetite."			
	The food intake documentation for March 2011 indicated the following:  3/1/11 intake of 15% at breakfast, 50% at lunch and dinner 3/2/11 intake of 25% at breakfast and lunch, 50% at dinner 3/3/11 intake of 50% at breakfast, refused lunch, 25% at dinner 3/4/11 50% at all 3 meals 3/5/11 50% at breakfast and dinner, 30% at lunch 3/6/11 50% at breakfast and dinner, 75% at lunch 3/7/11 50% at breakfast and lunch			
	The dietitian's note dated 3/3/11 indicated "Mar (March) wt (weight) 109.4 # down 7.6 # in 30 days (6%). Wt. loss due to low food intake. Res having emesis, intake			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064			(X2) MULTIP  A. BUILDING  B. WING		nstruction 00	(X3) DATE S COMPL 03/07/2	ETED	
	PROVIDER OR SUPPLIER		STI 35	STREET ADDRESS, CITY, STATE, ZIP CODE  3518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
	25%. Receiving add fortified for	ng shake tid. Will oods"						
	to thereuptic (s 2/18/11 low in encanced (sic) approaches we (NAS) (no add (enhanced). 2 preferences. weight, and lal Healthshakes to ordered."  The undated "Recommendat DON on 3/7/1 indicated "1. is to be obtained admission to the monitored of determined that weigh is stable the facility and	risk nutritionally due sic) diet need, takes, 3/3/11 diet need" The ere 1. Diet as ordered ded sodium). Honor food 3. Monitor intakes, bs as available. 4. tid. Supplements as  Weight Management ions" provided by the 1 at 1:20 P.M., The resident's weight ed at the time of the facility and should each week until it is at the new resident's e. If a resident leaved direturns to the ing an acute spell of						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A. BUILDING 00			COMPLETED	
		155064	- 1	B. WING			03/07/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIE	R			OUTH LAFOUNTAIN STREET			
FAIRMOI	FAIRMONT REHABILITATION CENTER, LLC				ло, IN46902			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	-	ID	<u> </u>		(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	· `	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	possible, weig	gh the resident before						
	they leave the	facility and						
	document. W	eigh the resident upon						
	return to the f	acility and document.						
	Monitor the w	veight of the resident						
	each week un	til it is evident that the						
	resident's wei	ght has stabilized. 2.						
	The physician	, the registered						
	dietitian, and	the responsible/legal						
	representative	e are to be notified						
	immediately v	when a resident has						
	demonstrated	a significant						
	unplanned we	eight loss or						
	gainRespor	nd promptly to the						
	physician ord	ers and the register						
	dietitian's reco	ommendations."						
	This federal ta	ag relates to complaint						
	IN00086620.							
	3.1-46(a)(1)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3HY411

000025

Facility ID:

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/07/2011		
	VIDER OR SUPPLIER	N CENTER, LLC	'	3518 S	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET MO, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE.	(X5) COMPLETION DATE
SS=G ar er fli re of sa fil sa	nd interview, insure a reside uids to prevent esulting in the following in the following including including including including including including including the resident A's or the right side of the curtain between the end of the ving in bed.  Ouring an interview in 3/4/11 at 10 adicated the resident A's or the curtain between 10 and 10 adicated the resident A's the curtain between 10 and 10 adicated the resident A's the curtain between 10 adicated the resident A's the cu	facility tour on A.M., with the of Nurses), wer bed table was on f the resident's bed, no water pitcher on call light was clipped reside the bed out of e resident who was  eview with the DON c:30 A.M., she esident didn't have dside, but the staff in fluids of cranberry	F032	27	Correcttive Action: Resident A water pitcher is removed relate use of Thickened Liquids as per facility policy. Resident is offer thickened liquids by staff frequently throughout the day. 3/4/11 new Dehydration Assessment completed and appropriate interventions were implemented per Care Plan.Identification: Current residents have the potential to affected by this deficient practic New baseline Dehydration Assements have been complet on current residents.Inservice of Licensed Nurses completed on use of new from.System Change: Implementaion of new Hydrations Risk Evaluation implemented to better evaluate residents hydration needs. Inta and Output initiated on all new admissions for 72 hours to establish baseline hydration needs, I & O implemented on those residents determined to be risk. Monitoring: I & O records are being reviewed dai (Monday thru Friday) by DON, /Designee or Charge Nurse to assess hydration issues. Audit are completed weekly for 3 week, monthly for 3 months and quarterly for 3 quarters. Any identified trends will be reviewed at our monthly clinical meeting and Improvement Plans implemented.Addendum: I & C records will be reviewed at the dalily Clinical meeting for residents determined to be at residents.	be ce. led for le ke	04/06/2011

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155064		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/07/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	reviewed on 3, Resident A's d but were not li kidney disease artery disease, dementia, CV/accident [strok weakness, HT: CABG (corona graft), bladder respiratory fail Resident A was facility on 2/1, A "Dehydratio was completed score was 8 in was at high ris. The facility did Resident A on following obseresident's men confused, able known at time recommendati	iagnoses included, mited to chronic e, dementia, coronary anemia, multi-infarct A (cerebral vascular te]) with right arm N (hypertension), ary artery bypass cancer, and lure.  In Risk Assessment'' d on 2/1/11. The total dicating the resident k for dehydration.			for Hydratrion issues. This review will include at least 10% residents on I & O . Any ident trends will be reviewed at the monthly Clinical meeting. Any continuing identified issues wi referred to our Quarterly QAA meeting. The QAA committee may discontinue any further monitoring if no trends are identified.	ified , Il be	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CC  A. BUILDING  B. WING	00		E SURVEY PLETED 2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	needed extens meal. Labs in (blood sugar), balance" The sesident A's e "set-up, partial assist."  The nurses' not indicated ""  The DM's (die progress note 12:27 P.M. inda NAS (no add dx (diagnosis) Weight 142.6 50-75% at meat meals. (nameals with no issues"  The daily Deh for February 2 resident was "This assessme completed on	ly Res. (resident) live assistance at dicate elevated BS adequate electrolyte he dietitian indicated ating ability was l assist, and full  Ites dated 2/3/11 Takes fluids well"  Petary manager) written of 2/8/11 at dicated "(name) is on ded salt) diet due to HTN (hypertension)  # Normal intakes als fluids 700-900 cc ne) is total assist at chewing/swallowing  ydration Assessment 011 indicated the at risk - monitor." nt had not been 2/1/11, 2/2/11, 2/6/11, 2/7/11,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE S COMPL		
				LDING		03/07/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				3518 S	OUTH LAFOUNTAIN STREET		
FAIRMONT REHABILITATION CENTER, LLC				KOKON	лО, IN46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
	2/8/11, 2/9/11,	2/10/11, 2/11/11,					
	·	11, 2/14/11, 2/15/11,					
	and 2/16/11. H	He was sent to the ER					
	(emergency ro	om) on 2/16/11 for					
	dehydration.						
	The Dietary In	take Record for					
	February 2011	indicated Resident A					
	had a total flui	d intake of 0 on					
	2/1/11, 0 on 2/2/11, 600 ml						
	(milliliters) on 2/3/11, 680 ml,						
	2/4/11, 720 ml	. on 2/5/11, 720 ml.					
	on 2/6/11, 720	ml. on 2/7/11, 720					
	ml. on 2/8/11,	840 ml. on 2/9/11,					
		0/11, 600 ml. on					
	· ·	nl. on 2/12/11, 720					
		, 480 ml. on 2/14/11,					
		5/11, 480 ml. on					
		as sent to the ER on					
	2/16/11 for eva						
	treatment of dehydration.						
		tes dated 2/16/11					
	indicated the fo	•					
		s family requesting					
	· · · · · ·	y,ureters,bladder)(an					
	l	odomen) done on res.					
	· · · · · ·	dominal pain,. Res,					
	also having itc	g					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155064		A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/07/2011
NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTI	3518 S	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET MO, IN46902		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDENT	BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
3:10 P.M. "KUB results'Abdomen is unremarkable" 6:20 P.M. " res to h (complete blood count (basic metabolic panel (immediately) Res. well @ (at) dinner. Well @ (at) dinn	ave CBC at) & BMP bl) STAT did not eat Vas fed a a res. let food" eived) call cal lab results. ogen) 98, results for He states to  2/16/11 ag: aich was a th normals of cinine was , with normals the sodium a critical high, 144 mmol/L, which was 198-108			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		(X2) MULTIPLE CO  A. BUILDING  B. WING	00		E SURVEY PLETED 12011	
NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER, LLC			3518 S	ADDRESS, CITY, STATE, ZIP COUTH LAFOUNTAIN ST MO, IN46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	cell) was 14.6, with normals of (hemoglobin) high, with normals of model of the control of the c	which was high, of 4.5 - 10.4, the HGB was 16.9, which was mals of 11.7 - 16.0 CT(hematocrit) was as high, with normals.  'Lippincott Manual of ce Handbook" third 352 & 353 in the id and electrolyte dicated "2. In the matocrit will be hypovolemia (low ration). 3. Blood urea reatinine will be hypovolemia, and the imbalances caused the solution. The contraction of the imbalances caused the solution of the imbalances caused the solution. The imbalances caused t				

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER: 155064   A. BUILDING B. WING   DO   O3/07/2011    NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE 3518 SOUTH LAFOUNTAIN STREET KOKOMO, IN46902    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL   PREFIX   CPACE OF RECEIVE ACTION SHOULD BE COMES DEFERENCE TO THE APPROPRIATE   COURSE OF RECEIVED TO THE APPROPRIATE   COURSE OF RECEIV	
NAME OF PROVIDER OR SUPPLIER  FAIRMONT REHABILITATION CENTER, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE CO)	OMPLETION
NAME OF PROVIDER OR SUPPLIER  53518 SOUTH LAFOUNTAIN STREET  KOKOMO, IN46902  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE CO	OMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	OMPLETION
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO)	OMPLETION
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COORD REPROSED THE ADDRODUME CO.	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
hypernatremia, pneumonia,	
dehydration et acute RF (renal	
failure)."	
A progress note from the hospital	
dated 2/20/11 indicated the resident	
had "1. acute renal failure related to	
dehydration. 2. Chronic renal	
failure"	
Resident A's Admission Plan of	
Care dated 2/1/2011 indicated a	
problem of "Pot. (potential) for	
dehydration r/t (related to) new	
admission to ECF (extended care	
facility)." The interventions	
included, but were not limited to,	
"1, Nurses will monitor/document	
signs/symptoms of dehydration for	
5 days. 2. Evidence of dehydration	
will be reported to physician	
immediately. 3. FSM (Food	
Service Manager) will determine	
fluid preferences of the resident. 4.	
FSM will provide fluid preferences	
of the resident at bedside, on	
hydration cart & with meals. 5.	
CNA's will doc. (document) fluid	
consumption and report resident	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
155064		A. BUI B. WIN	LDING NG		03/07/2	011	
NAME OF PROVIDER OR SUPPLIER			·	1	NDDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET		
FAIRMONT REHABILITATION CENTER, LLC				1	10, IN46902		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
		s to charge nurse. 6.					
		te will be reviewed					
	1 '	nutrition at risk)					
		h week for 4 weeks					
		zed. 7. Observed for					
	symptoms of U	J11."					
	   Resident A's C	Care Plan for					
		dated 2/2/2011 for					
	the problem of "At risk for						
	1 -	ndicated the resident					
	"will consume	at least 1200-1800					
	cc (cubic centi	meters) of fluids per					
	day to meet calculated						
	requirements."	The approaches					
	included, but v	were not limited to					
	" Monitor fo	or physical					
	signs/sympton	ns of dehydration"					
	<b>.</b>	1. 1. 2					
		urned to the facility					
		with diagnoses of					
	"hypernatremi	a, acute renal					
	failure."						
	A "Dehydration Risk Assessment"						
	was completed on 2/24/11. The						
	_	s 8 indicating the					
	resident was a	~					
	dehydration.	S					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155064		A. BUI	LDING	NSTRUCTION  00	COM	TE SURVEY MPLETED 7/2011	
NAME OF PROVIDER OR SUPPLIER  FAIRMONT REHABILITATION CENTER, LLC			B. WIN	3518 SC	DDRESS, CITY, STATE, ZIP CO DUTH LAFOUNTAIN ST 10, IN46902	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	3/3/11. This reflected Resident A had needs of 1980  The February Coutput Record following intal 2/24/11 - 360 c 2/25/11 - 2040 2/26/11 - 1560 2/27/11 - 1460 2/28/11 - 1460  There were no 2/24/11.  The March 20	of the resident on eassessment indicated d estimated fluid cc/day.  2011 "Intake and l" indicated the kes: c for one shift only cc cc cc entries before  11 "Intake and l" indicated the kes:					
		11 "Dietary Intake ated Resident A had					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N	AULTIPLE CO.		COMPI		
155064			ILDING	00	03/07/2		
		100001	B. WI		DDDDGG CITY CTATE ZID CODE	00/01/2	.011
NAME OF PROVIDER OR SUPPLIER				1	DUTH LAFOUNTAIN STREET		
FAIRMONT REHABILITATION CENTER, LLC				1	10, IN46902		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BLITCLENCT		DATE
	_	l of fluids on 3/1/11,					
		aids on 3/2/11, 1080					
	ml of fluids on	13/3/11.					
	Review of the	undated "Hydration					
		vided by the DON on					
		:15 A.M., indicated					
		keep each resident					
	-	ide water will be					
	-	other fluids will be					
		between meals.					
		idelines: A. All					
	residents will b	be offered fluids with					
	each meal. Fro	esh ice water will be					
	at the bedside	of each resident					
	unless the resid	dent specifies that					
	they do not lik	e ice water F.					
	*	to be documented					
	using the Food	l Consumption					
	_	-					
	Record or an Intake and Output Record."						
	Record.						
	   This federal ta	g refers for complaint					
	IN00086620.	5 101010 for complaint					
	11100000020.						
	3.1-46(b)						
	J.1-40(0)						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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2. (12. (12. (12. (12. (12. (12. (12. (1								
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00  B. WING		00		COMPLETED 03/07/2011	
		155064						
FAIRMOI	PROVIDER OR SUPPLIER	ON CENTER, LLC	P. WII.	STREET A 3518 SO KOKON	ADDRESS, CITY, STATE, ZIP CODE OUTH LAFOUNTAIN STREET MO, IN46902			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL					COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3HY411

Facility ID: 000025

If continuation sheet

Page 33 of 33